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### CHAPTER 3. PATIENT CARE ISSUES

#### 3.01 SAFETY ISSUES

a. The safety of the HBHC patient, the caregiver, the home environment, and the HBHC team members should be carefully addressed by all HBHC programs.

b. An assessment of the patient's home environment to identify safety hazards that could result in injury to the patient and caregiver will be performed and documented upon admission of the patient to the HBHC program. Appropriate steps to reduce or minimize the risks to the patient, home caregiver and HBHC team members should be instituted by the HBHC Team or recommended to the patient and home caregiver for action. Monitoring of the patient, home caregiver and team members' safety should be an on-going process for as long as the patient is in the HBHC program.

c. Each HBHC program will have a system of documenting, evaluating and reporting accidents and injuries and for documenting safety hazards. The aggregate results of these evaluations will be considered during the review of the quality and appropriateness of patient care provided by the HBHC Team.

#### 3.02 INFECTION CONTROL

a. Universal precautions to prevent the spread of infection and the U.S. Environmental Protection Agency guidelines for disposal of biohazardous waste in the home are an integral part of the HBHC patient and staff education and performance.

b. A system for documenting, evaluating and reporting all infections in the HBHC patient population will be monitored for trends and preventable factors. Infection control results and evaluations should be considered during the annual review of the quality and appropriateness of patient care. Aggregate results of the data will be reported to the appropriate medical center authority.

#### 3.03 EMERGENCY PREPAREDNESS

Each HBHC program will have an emergency preparedness plan designed to provide continuing care and support to the patient in the event of an emergency that could result in an interruption of patient care services by the HBHC team. Natural disasters, civil disturbances, power outages, unplanned absence of staff or home caregiver, etc., need to be considered as they apply to individual patients. Patient and caregiver will be educated in emergency preparedness. A plan corresponding to these circumstances must be developed, monitored, and evaluated on a regular basis.

#### 3.04 MENTAL HEALTH ISSUES

While HBHC does not target psychiatric patients as its service population, many HBHC patients have concurrent mental health problems often including depression, anxiety, behavioral problems, or cognitive impairment. A

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consultation/liaison relationship should be established with Psychiatry and Psychology Services for the assessment, treatment and management of these problems. Within this relationship, in-service training sessions can be developed to hone skills in mental assessments and interventions and to increase knowledge of depressions, confusion, suicide threats or gestures, caregiver abuse, etc. Such sessions or individual consultation can be useful to team members in managing

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the patient and in developing strategies to avert a crisis in the home. The consultation/liaison relationship includes assessment and treatment of individual patients or family members, and indications and procedures for obtaining direct mental health treatment.

## 3.05 CRITICAL CARE PLANNING/DO NOT RESUSCITATE ORDER IN THE HOME

As part of each person's right to self-determination, every HBHC patient may accept or refuse any recommended medical treatment. It is recognized that the majority of HBHC patients have either a debilitating chronic disease or terminal illness and are faced with the need to make decisions about extraordinary life support measures. Each HBHC program will have a policy guaranteeing patients' right to make these decisions. Procedures outlined in each medical center's "Do Not Resuscitate Policy" should be examined and adapted to the care of patients in their homes.

## 3.06 MEDICATION USE IN THE HBHC PATIENT POPULATION

Medication management in the care of the elderly and chronically ill is an area which requires significant attention by the interdisciplinary team. Specific policies addressing selection and clinical evaluation of drugs for therapeutic appropriateness must be established to offset the high potential for side effects, polypharmacy and compliance problems in this population. In addition, procedures and protocols to guide the team in the delivery, instruction, storage, and monitoring of drugs must be developed with particular attention to the administration of parenteral, intravenous and nebulized medications in the home setting.

## 3.07 HOME MEDICAL EQUIPMENT

The JCAHO Home Care Standards for Accreditation relate to all home medical equipment including ambulation and bath aides; oxygen services; life-sustaining and/or custom electrical equipment; and intravenous pumps. Under these standards, the HBHC team is responsible for assessing and prescribing appropriate medical equipment for HBHC patients and for teaching the patient and caregiver the proper and safe use of the equipment. The team documents this assessment and instruction. Further, the team monitors the patient and refers any equipment related problems to the appropriate staff person. Prosthetic and Sensory Aids Service, and other services involved with the provision of home medical equipment, are responsible for meeting and ensuring that home equipment contractors meet all of the JCAHO Home Care Standards for Accreditation.

## 3.08 REFERRALS TO COMMUNITY SERVICES

HBHC patients will be referred to community resources upon discharge from the HBHC program if needed to meet their continuing care needs. Relevant information is provided to the patient and/or family regarding the resources available to meet the identified needs so that they can be active participants in the planning of referral by the HBHC program. When the patient is referred for the services of another organization, relevant information is given to the

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proposed provider after obtaining a patient's release of information. In addition, referrals will be made when services needed by the HBHC patient are not provided by VA, such as home health aide care, homemaker, home-delivered meals or legal assistance. When supplementary services are to be provided to the patient by a community resource in conjunction with HBHC care, they will be coordinated with those provided by the team. VA is not responsible for payment of these services nor is any reimbursement received for referrals.

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3.09 RESPITE CARE

a. The provision of 24-hour continual care is stressful to family caregivers. A plan for providing caregivers with some type of intermittent, short-term respite may assist in reducing this stress, thereby, facilitating the care of the patient in the home. There are three generally recognized models of respite care:

(1) In-Home, e.g., personal care, chore service, professional nursing, paid or volunteer companion.

(2) Out-of-Home, e.g., adult day care, support group, or institutional care.

(3) Combination plan.

b. The VA Respite Care Program, an Out-of-Home model, is defined as a program of limited duration; is furnished in a VA medical center or Nursing Home Care Unit; and is for the purpose of helping the veteran to continue residing primarily at home. Some HBHC programs utilize volunteers for In-Home respite through the SCP (Senior Companion Program) and the RSVP (Retired Senior Volunteer Program).

3.10 CAREGIVER SUPPORT

a. HBHC considers the patient and the patient caregiver as the unit of care. Without the caregiver, the maintenance of the severely chronically ill in their homes would be an impossibility. Yet HBHC providers recognize that the burden of care can be very great with high social, psychological, physical and economic costs.

b. While HBHC cannot treat the non-veteran caregivers, HBHC team members can continually assess the well-being, functional capacity, and general health status of the caregiver. Recognition of the role of the caregiver, the unique stresses and strains of each caregiver's situation, and appropriate intervention to prevent the unnecessary breakdown of the caregiver/patient relationship are the responsibility of HBHC. Supportive home visits by the HBHC team members and VA and community programs designed for caregivers should be utilized to enhance the caregiver's coping ability.

3.11 BEREAVEMENT SERVICES

Upon the death of the veteran, visits to the surviving spouse or other significant individuals may continue for up to six months, if clinically indicated, to facilitate the bereavement process. The medical center Director may approve a longer period of time when medically indicated.

3.12 DEATH IN THE HOME

HBHC adheres to the Hospice philosophy and offers palliative and supportive services to the terminally ill patient. The goals are to help the terminally

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ill patient achieve maximum emotional well-being and freedom from physical pain; to keep him/her functioning at a maximal level so that he/she can live as fully as possible until death comes; to address any special needs of the patient and family members that arise from the stresses associated with the final stages of illness, dying and bereavement and to clarify the veteran's and family's wishes regarding life-sustaining efforts before death and procedures following death.